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Response to the 2011 Question of the Year: What improvements in medical education will lead to better health for individuals and populations?

Professionalism, the Invisible Hand, and a Necessary Reconfiguration of Medical Education

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The nation teeters on the precipice of financial insolvency. Health care costs darken the economic horizon. Public trust in medicine is at an all-time low. Meanwhile, medical educators reconfigure their curricular cornerstones at a dizzying rate. Basic science course work is integrated with clinical, training with delivery, undergraduate with graduate and CME, education with mission, and the formal with the multitude of other-than-formal dimensions of the educational citadel. Competencies, milestones, and landmarks are being created, catalogued, and coordinated. In the end, however, none of this will matter. Whatever the pedagogical fix, one largely ignored, if unintended, consequence of medical education remains indelible. Medical training has become an institutionalized process of elevating an already privileged (educationally or otherwise) group into an even more elite social class. Trust may be withering, but power and privilege (particularly when it comes to defining, diagnosing, and treating disease) remain. Meanwhile, patients and their families fear retribution if they question their doctors.[1] A rift between the public and those sworn to serve their needs deepens.

Key to this alienation is that physicians lack insight into the economic and social burden of the services they orchestrate.[2] As a consequence, the most pernicious threat to health care and medical education in the United States today is not patient safety, nor the lack of an evidence-based practice, but rather the alienation of trainees and physicians from the financial cost to patients of their work.

We propose, therefore, a training process organized not around disciplines, organ systems, diseases, or clinical problems, but around cost. Beginning with the admission process, all medical school applicants will be required to demonstrate proficiencies in micro-, macro-, behavioral, and health care economics, and to document community service and related shadowing experiences in clinic business offices or sites related to the recording and payment of medical charges. A new MCAT exam, Kaplan course work, and premed advising will all mirror this shift.

On matriculation, all students will begin their training with a range of focused educational activities designed to increase and improve their "cost-consciousness." To this end, the medical school (and not just the curriculum) will be reorganized so that all members of the educational community are grounded in an experiential understanding of cost and its relationship to health care access and the burdens of treatment.[3] Administrators must learn how to create and present translucent budgets and to coordinate those budgets so that they reflect the values of affordable and trustworthy medical care. Faculty (and this means anyone coming in contact with a trainee in his or her capacity as a teacher/facilitator) must become "cost literate" prior to working with students. Faculty development programs must be developed to these ends.

The first two months of medical school (with preexisting courses taxed to create this curricular space) will be devoted to the economics of care. This block will involve multiple pedagogical approaches from traditional didactics and problem-based learning to simulation and social networking. Instructors will range from topic experts to patients and members of the public whose lives are being bludgeoned by health costs.

Preceptorships will be community based and will focus on student experiences in educating the public on the

cost of both schooling and health care. Once this competency is mastered, students will begin to meet with patients upon discharge (clinic or hospital) to explain all charges. There will be no traditional "patient care" contact until students are fully able to decode and explain the highly cryptic billing statements that encumber patients. As students enter the biomedical side of their training, patient meetings will begin to add explanations of diagnoses and treatment options to those of cost. No student will be admitted to the care side of the educational continuum until he or she is fully able to explain to patients what has been done to them and why. As students move into residency training, they periodically will be shifted from their clinical responsibilities into the discharge process to recheck on their decoding and explaining competencies. National boards will reflect this new mandate. So, too, will CME requirements, which will include mandatory credits in cost competency. Cost will be defined as a major burden of treatment, with "burden of treatment" a major reframing of how we conceptualize and approach health care.[3]

We seek to provide a system of training that will produce true patient-centered practitioners, a bona fide revolution in what it means to practice medicine, a physician workforce prepared to lead, and a true profession willing and able to regulate itself on behalf of the public.

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Extremist Proposal Shocks the Medical Establishment

Written by Daniel Wolfson on January 31, 2012

I suspect many were shocked, even disturbed, upon reading the article, *Professionalism, the Invisible Hand, and a Necessary Reconfiguration of Medical Education* by distinguished professor of medical education at Mayo Clinic, Fred Hafferty, and his two colleagues, Drs. Brennan and Pawlina. In the article, the authors call for all medical students to achieve competency in the economics of care prior to seeing their first patients. They state:

"There will be no traditional 'patient care' contact until students are fully able to decode and explain the highly cryptic billing statements that encumber patients. As students enter the bio-medical side of their training, patient meetings will begin to add explanations of diagnosis and treatment options to those of cost."

Does this sentiment fly in the face of the professionalism's commitment to the primacy of the patient? Or, does this radical notion of costs being taught prior to and during medical school provide a fresh way of thinking about medical education's role in teaching about the Triple Aim that includes cost? Professor Hafferty challenged the status quo once before when he revealed the sociological construct of the hidden curriculum and a system approach to professionalism. Perhaps he's doing so again…

Is this merely the authors' radical notion or is it aligned with what needs to happen if the nation is to prevent financial ruin? Given the cost of care and waste in the system, we need bold, new ways of thinking by physicians and thought leaders such as this.

Organizations such as CMS and Institute for Healthcare Improvement have called for a focus on the Triple Aim – outcomes of care, patient experience and affordability. Yet, most quality and safety departments in hospitals and medical groups focus more on eliminating unnecessary steps in a process rather than identifying inappropriate diagnostic tests or treatments. Thus the more fundamental question arises of what exactly "it" is that provides very little additional information or benefit in the quest for good medical care.

Dr. Steve Weinberger, Executive Vice-President of the American College of Physicians, calls for high–value, cost-conscious care as the seventh competency to be required by the Accreditation Council for Graduate Medical Education and specialty certifying boards. Identifying cost as a distinct component will send a strong signal and help generate the proper attention it needs.

So are these co-conspirators wacky agitators or have they suggested a bold new initiative?

Vinny Arora February 1, 2012 at 7:34 pm | Many medical students and residents want to know how much things cost but they can't find out the answers since there is no transparency and everything is so cryptic. The irony here is that medical schools will need to recruit a health administrator from their hospital to teach students how to decipher a hospital bill! Lastly, as the hidden curriculum (as Dr. Hafferty knows well) is powerful! So any instruction will be undone by watching faculty who may encourage overtesting and overuse

Daniel Wolfson February 2, 2012 at 12:23 pm | Vinny, Thanks for your astute comments. Hospitals do know what they charge- they just have different charges for different payers. The charges have no relationship to the real cost of providing the service. AMCs should call on their public health schools and their health care business administration programs to help teach about the economics of health care. Hospitals saying "no" to providing prices of care is not acceptable any longer. Medical students and residents need to voice their concerns about the costs of care and be leaders in this arena. - Daniel

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Providing High-Value, Cost-Conscious Care: A Critical Seventh General Competency for Physicians

Steven E. Weinberger, MD

There is general agreement that the U.S. economy cannot sustain the staggering economic burden imposed by the current and projected costs of health care. Whereas governmental approaches are focused primarily on decreasing spending for medical care, it is the responsibility of the medical profession to become cost-conscious and decrease unnecessary care that does not benefit patients but represents a substantial percentage of health care costs. At present, the 6 general competencies of the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) that drive residency training place relatively little emphasis on residents' understanding of the need for stewardship of resources or for practicing in a cost-conscious fashion. Given the importance in today's health care system, the author proposes that cost-consciousness and stewardship of resources be elevated by the ACGME and the ABMS to the level of a new, seventh general competency. This will hopefully provide the necessary impetus to change the culture of the training environment and the practice patterns of both residents and their supervising faculty.